VFC PIN: ___ ___ ___ ___

Montana Vaccines for Children Program
VACCINE ELIGIBILITY FORM - for Private Practices

Accountability Period

From: _____ /_____ /_____

To: _____ /_____ /_____

PATIENT ELIGIBILITY STATUS
(Check ONE BOX for each child at FIRST VISIT ONLY!)

VACCINE DOSES ADMINISTERED

You may use check marks for each dose administered.

	Name	Date of Birth	Date of Service (mo / day)	Age is under 1 Year: MEDICAID	Age is under 1 Year: NO INSURANCE	Age is under 1 Year: AMER. INDIAN or ALASKA NATIVE	Age is 1 through 6 Years: MEDICAID	Age is 1 through 6 Years: NO INSURANCE	Age is 1 through 6 Years: AMER. INDIAN or ALASKA NATIVE	Age is 7 through 18 Yrs: MEDICAID	Age is 7 through 18 Yrs: NO INSURANCE	Age is 7 through 18 Yrs: AMER. INDIAN or ALASKA NATIVE	DTaP (or Ped DT *)	TriHIBit (DTaP + HIB)	Hep B	HIB Pedvax (or ActHIB * [A])	IPV	COMVAX (Hep B + HIB)	Pediarix (DTaP + Hep B + IPV)	Pneumococcal PCV (or PPV *)	Rotavirus	MMR	VAR	ProQuad (MMRV)	Hep A	Influenza - .25 dose	Influenza - .5 dose	Influenza - Flumist	Tdap (or Td *)	Meningococcal MCV4 (or MPSV *)	Human Papillomavirus (HPV)
1			/																												
2			/																												
3			/																												
4			/																												
5			/																												
6			/																												
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Provider's Signature: **Date:**

TOTAL DOSES GIVEN AT VFC VISITS ONLY - Use these numbers to calculate projected usage when ordering vaccine